TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Christopher Turner, D.C.

**Respondent Name**
Travelers Property Casualty Company of America

**MFDR Tracking Number**
M4-17-1324-01

**Carrier's Austin Representative**
Box Number 5

**MFDR Date Received**
January 9, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION/PARTIAL PAY"

**Amount in Dispute:** $900.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Provider contends they are entitled to an additional $900.00 for CPT code 99456. The Carrier has reviewed the billing and agrees that additional reimbursement is due, however, disagrees that additional reimbursement is due in the amount of $900.00. The Maximum Allowable Reimbursement for this Designated Doctor evaluation was originally calculated based on the Maximum Medical Improvement evaluation of $350.00. The Provider is entitled to an additional $150.00 for the DRE assessment, $300 for the first musculoskeletal body area (the upper extremities), and $150.00 for the second musculoskeletal body area (the lower extremities). The Carrier contends supplemental reimbursement is therefore due in the amount of $600.00 and issuing payment of the same."

**Response Submitted by:** Travelers

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 9, 2016 | Designated Doctor Examination (99456-W5-WP) | $900.00 | $300.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services provided from March 1, 2008 until September 1, 2016.

3. Submitted documentation did not include explanations of benefits submitted to the health care provider prior to the request for medical fee dispute resolution.

**Issues**

What is the maximum allowable reimbursement (MAR) for the services in dispute?

**Findings**

Christopher Turner, D.C. is seeking an additional reimbursement of $900.00 for a designated doctor examination to determine maximum medical improvement and impairment rating. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the MAR for this examination is $350.00.

28 Texas Administrative Code §134.204(j)(4) states:

(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
  (i) Musculoskeletal body areas are defined as follows:
    (I) spine and pelvis;
    (II) upper extremities and hands; and,
    (III) lower extremities (including feet).
  (ii) The MAR for musculoskeletal body areas shall be as follows.
    (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
    (II) If full physical evaluation, with range of motion, is performed:
      (-a-) $300 for the first musculoskeletal body area; and
      (-b-) $150 for each additional musculoskeletal body area.

(D) …
  (i) Non-musculoskeletal body areas are defined as follows:
    (I) body systems;
    (II) body structures (including skin); and,
    (III) mental and behavioral disorders.
  (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides…
  (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

Review of the submitted documentation finds that the requestor provided impairment rating evaluations for the left shoulder, left hip, cervical spine, thoracic spine, lumbar spine, chest/rib contusion, and abdomen/groin contusion. The MAR for this examination is calculated as follows:

| Examination | AMA Chapter | §134.204 Category | Reimbursement Amount |
|---|---|---|---|
| Maximum Medical Improvement | | | $350.00 |
| IR: Left Shoulder (ROM) | Musculoskeletal System | Upper Extremities | $300.00 |
| IR: Left Hip (ROM) | | Lower Extremities | $150.00 |
| IR: Cervical/Thoracic/Lumbar Spine (ROM) | | Spine & Pelvis | $150.00 |
| IR: Chest/Ribs | Respiratory System | Body Systems | $150.00 |
| IR: Abdomen/Groin | Digestive System | Body Systems | $150.00 |
| **Total MMI** | | | **$350.00** |
| **Total IR** | | | **$900.00** |
| **Total Exam** | | | **$1,250.00** |

The total MAR for the services in dispute is $1,250.00. Travelers Property Casualty Company of America reimbursed $950.00. An additional reimbursement of $300.00 is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $300.00.

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | Laurie Garnes | March 17, 2017 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.